



Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Agency of Human Services

~ BISPSPHONATE INJECTABLE – BONIVA AND RECLAST ~
Prior Authorization Request Form

Vermont Medicaid has established criteria for prior authorization of Boniva IV and Reclast. For beneficiaries to receive coverage for these agents, it will be necessary for the prescriber to telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name: _____
Phone #: _____
Fax #: _____
Address: _____
Contact Person at Office: _____

Beneficiary:

Name: _____
Medicaid ID #: _____
Date of Birth: _____ Sex: _____
Diagnosis: _____

Will this medication be billed through the: ☐ **pharmacy benefit** or ☐ **medical benefit** (J-code or other code)?
(Please check one)

Pharmacy (if known): _____ Phone: _____ &/or FAX: _____

Drug requested: ☐ Boniva IV ☐ Reclast

Dose & frequency: _____

Diagnosis/indication:

- ☐ Treatment of postmenopausal osteoporosis
☐ Paget's Disease
☐ Other (Please Explain) _____

Has the member previously tried the following preferred medications? (Please check all that apply)

Drug:	Response:
<input type="checkbox"/> Boniva Oral	<input type="checkbox"/> side-effect <input type="checkbox"/> treatment failure* dates of use: _____
<input type="checkbox"/> Fosamax Oral	<input type="checkbox"/> side-effect <input type="checkbox"/> treatment failure* dates of use: _____

*Treatment failure is defined as documented continued bone loss after two or more years despite treatment with the bisphosphonate.

Prescriber comments:

Prescriber Signature: _____

Date of this request: _____